

Working in partnership: the application of shared decision making to health visitor practice

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Abstract

Aim and objectives

To explore the processes which support shared decision making when health visitors and parents are making plans to improve the wellbeing of babies and children.

Background

Worldwide there is a focus on promoting children's wellbeing in order to enhance population health, and within the United Kingdom health visitors have a key responsibility for working in partnership with parents to support this agenda. Despite evidence that shared decision making can increase patient participation, improve patient satisfaction, and improve health outcomes, there is limited research linking shared decision making with health visitor practice.

Design

A qualitative, descriptive study

Methods

The researcher audio recorded two parent:health visitor dyads who were planning together as part of usual care, and then the participants' views about their experiences were sought through individual questionnaires. Subsequently nine health visitors and nine parents were interviewed individually about their recent experiences of planning care.

Results

Evidence of supportive processes included having a shared understanding around the issue needing to be addressed; being able to identify interventions which were physically and psychologically accessible for the family; engaging in decision making through deep, meaningful conversations using sensitive and responsive approaches; and establishing positive relationships between health visitors and parents, significant others within the family, and other professionals.

Conclusion

Despite evidence of strong trusting relationships between parents and health visitors, this study has shown examples where shared decision making was challenging when other supportive processes were absent.

Relevance to clinical practice

Health visitors are aware that planning interventions in partnership with parents can be complex. These findings have created awareness of the potential value of using a shared decision making framework to structure planning in collaboration with parents, and has highlighted a number of areas for practice development.

Key words – public health nursing, health visiting, shared decision making, practice development

Introduction

There is recognition worldwide that the status of children's wellbeing within a community will have a direct impact on that population's future health, and consequently many developed countries ensure that there is investment in the 'Early Years'. This approach is noticeable across the United Kingdom, where the delivery of health services is devolved to each of the four countries, and where each government, or administration, invests in policies and programmes which aim to promote the wellbeing of their babies, children and young people (Scottish Government and COSLA 2008; Royal College of Nursing 2011) .

Health visitors in the United Kingdom are in a strategic position to be able to support this agenda because, as registered public health nurses, they have responsibility for promoting and safeguarding the wellbeing of babies and children as a key part of their role (Nursing & Midwifery Council 2004).

Background

Getting It Right For Every Child (GIRFEC) is a Scottish Government Programme (Scottish Government 2013a) based on the United Nations Convention on the Rights of the Child (UNCRC) (1990) and all professionals who work with children and families in Scotland are being encouraged to adopt GIRFEC principles. Consequently, health visitors are starting to use the GIRFEC National Practice Model to structure their assessments, analyse their findings, and then to support their practice if they need to create and implement plans for a baby or child (Scottish Government 2013b).

Within the UNCRC's 54 Articles there are 23 references to the important roles and responsibilities which parents have in relation to ensuring their child's wellbeing; as a direct result GIRFEC principles stress the importance of professionals and parents working together to support, promote and safeguard the wellbeing of babies and children. This means that where interventions are required, to ensure a baby's or child's wellbeing, health visitors and parents should ideally work in partnership (where it is safe and in the best interests of the child to do so) in order to decide whether to implement evidence based interventions from within the health visitor team's resources or whether to make a decision to request assistance from a range of other local agencies and professionals who are available to work with families.

Shared decision making models, or frameworks, are used within a range of healthcare practice and create structure when health professionals are making decisions in partnership with patients. Current research is beginning to identify strengths in terms of increased patient satisfaction, patient engagement and improved patient outcomes (Adams and Grieder 2014) . However, despite these positive results, there is little evidence of shared decision making frameworks being applied within health visiting practice. In order to explore this area of practice further a qualitative research study was designed.

Aim and objectives

The aim of the study was to describe what was currently happening when health visitors and parents were making decisions and planning interventions together with a view to exploring what specific processes supported shared decision making in this context of health visitor practice.

What is Shared Decision Making?

It is evident from the literature that shared decision making is viewed in a number of ways. For instance there is an opinion, supported by some academics and theorists, and cited in Siminoff and Step (2005), that the ideal shared decision making encounter is one based on normative decision making theory where two people, with equal power and the required knowledge and skills, come together to make a decision in a context where there is shared understanding of the purpose, the issue and the processes. Here all options are given equal and fair consideration and both parties have the capacity and capability to share their views, values and beliefs with each other about what should happen next. A number of authors, however, whilst acknowledging the value of this optimum state have expressed that all of these criteria are unlikely to be met in the real world of patient care. They have therefore chosen to focus on finding ways of achieving the best possible outcomes for patients, and although still based on shared decision making theory they have taken a more descriptive, realistic approach. Authors, such as Charles et al (1997) and Charavel et al (2001), have focused on creating resources such as models, frameworks, decision aids, check lists and training packages which aim to improve the interactions between both parties, along with evaluations to determine the impact of the tools in practice (Gafni et al 1998; Charles et al 2003; Edwards and Elwyn 2006; Edwards and Elwyn 2009).

A number of Elwyn's shared decision making research studies have taken place within Primary Care where General Medical Practitioners (GPs) have been supporting patients with long term conditions, where partnerships have built up over years between patients and the GP, and where there is an acknowledgement that long term relationships can have a direct impact on the quality of the shared decision making (Elwyn et al 1999) . Health visitors work within a similar context as they often establish relationships with parents and carers of children in their caseloads over a number of years; and it was because of this similarity in practice that Elwyn's Framework was chosen to inform the study.

Study Design

The study was descriptive and conducted in two phases. Phase 1 involved audio recording conversations between health visitor and parent dyads and then collecting each participant's perspective of the planning experience. Phase 2 consisted of individual semi structured interviews with health visitors and parents, asking them about their past experiences of planning interventions in relation to a baby's or child's wellbeing. The study was informed throughout by Elwyn's Shared Decision Making Framework (Elwyn et al 2012).

Ethical considerations

Ethical approval was given by University of Stirling School of Health Sciences Ethics Committee and the NHS Research Ethics Service, and permission was given to collect data in two health board areas in Scotland; both with mixed demographics in relation to affluence and deprivation but where one area was predominantly rural and the other predominantly urban.

Data collection

Health visitors were recruited by the researcher visiting the area, meeting with health visitors in small groups to generate interest in the study, distributing literature explaining the purpose of the study, answering questions, and then waiting for offers to participate.

Sample

The sampling approach for health visitors was purposive, with the intention of creating variation across the health visitors' caseloads. There was an aim to ensure that the health visitor participants, between them, were currently managing different types of caseloads ranging from those taken from predominantly affluent areas to those from within more

deprived areas. This approach was adopted in case it became apparent, during the study, that the demographics within caseloads were influencing the data; however in reality all health visitors who participated described their caseloads as 'mixed' and there was no indication of any need to be selective about which health visitors to invite to participate.

The health visitors who volunteered to participate in Phase 1 had been able to recruit a parent from their caseload who was in the process of making a decision with them, and was willing to consent to participate in the study. The health visitors who volunteered to participate in Phase 2 of the study felt that they had the ability to reflect on an experience of supporting at least one parent to make a decision within the previous six months.

The parents who were recruited to participate in Phase 2 had been informed about the study from their health visitor on the basis that they had made a decision about an intervention on behalf of their baby or child, in partnership with their health visitor, within the last six months; and were willing to talk about their experience. This was convenience sampling.

Methods

In Phase 1 data was collected by audio recording two health visitor: parent decision making conversations, in the absence of the researcher, where decisions around planning for a baby or child were being made as part of usual care. Following the discussion each of the four participants were asked to complete an individual questionnaire based on Elwyn's OPTIONS questionnaires (Elwyn et al 2013). These questionnaires have been validated for quantitative studies in order to establish the extent to which shared decision making has taken place within encounters; however, the purpose of the questionnaire in this qualitative study was to collect the participants' interpretations of their experiences.

The nine health visitors and nine parents, who offered to participate in individual semi structured interviews, were audio recorded recalling an experience of planning around the needs of a baby or child. Each of the two semi-structured interview schedules (one designed for the health visitor and one designed for the parent) included questions which would inform if, and how, any aspects of shared decision making had been implemented. Each also included open ended questions which provided further insight into the experiences of participants when deciding which interventions to access for the baby or child.

Analysis

The twenty recordings were transcribed *verbatim* and analysis was supported by NVivo 10 using the framework analysis method as applied by the National Centre for Social Research (Ritchie et al 2014). Upon analysis 267 different labels were generated, which were then assigned to themes and presented in a framework matrix with the twenty recordings.

Results

In addition to the three identified themes of 'Choice Talk', 'Options Talk' and 'Decision Talk' from Elwyn's Framework, additional themes became evident. Of these, two themes stood out as being particularly important, and some of the related findings are reported here along with Elwyn's three themes.

The first additional theme, 'Identifying the Issue', was important because the quality of the discussions around the issue, in relation to the child's wellbeing, and the level of shared understanding of the importance of the issue between the health visitor and the parent, had an impact on what happened next. The second theme 'Relationships' was chosen because this theme threaded its way through every aspect of each of the other themes.

Identifying the Issue

Wood's (2013) definition of an 'issue', which is described as anything which 'gets in the way' of a baby's, child's, or young person's wellbeing, was applied during the interviews with the parents and health visitors.

The findings indicated that where the issue was clearly defined by the health visitor or the parent, and was related to the child, there was evidence of decision making processes and a focus on resolving the issue; however in cases where the issue wasn't clearly defined discussions between the health visitor and parent were less focused and there was less evidence of decision making and related planning.

In addition, even if there was agreement about what the issue was, there was not always a shared understanding or agreement, between the health visitor and the parent, about the importance of the issue to the baby or child's wellbeing; as in three examples the health visitors reported having differing views from the parents around a child's speech or behaviour, and in each of these cases there was reluctance of parents to engage with other services. In two of the cases discussed, the parents, who had unmet needs in their own

lives, did not appear to have the insight to understand the extent to which their personal issues, of drug and alcohol misuse, impacted on their baby or child's wellbeing.

What hindered discussions and shared understanding around the issue?

The challenges of working with parents with a range of intellectual abilities (including parents with learning disabilities) were identified, along with relating to parents from different cultures, the need to use an interpreter, and parents' lack of understanding about child development.

There were occasions when the complexity of family life got in the way of clarity about what issue needed to be addressed first, as there were multiple issues and the parents' priorities were prone to change with each health visitor contact.

their household was quite busy, so we had the two little girls, one's three and one's one and a half, both running about in the living room..... the television was on so it was quite a kind of noisy visit.....they were throwing a lot of issues at me! So, you know, 'she's not sleeping all night and her behaviour's terrible and she's not eating properly' and this and that, so there was a lot of different things
(Phase 2 HV 5)

Three health visitors described how they were unsure about how to explain 'wellbeing' to parents in language which the parents could understand – particularly when the discussion related to babies.

What supported discussions around the issue?

The use of evidence based tools and resources to assess cognitive development supported health visitor findings and were found to be helpful; not only as an evidence base for their own decision making but to support discussions with parents. However the availability of training in the use of evidence based tools and resources varied amongst health visitors at the time of the study – although what was available appeared to make a valuable contribution to discussions and negotiations when sharing decision making with parents.

Evidence based parenting programmes and approaches, which reinforced the need for parents to understand child development in order to understand their child's behaviour in a more realistic way, were found to be helpful. Examples where managers and professionals from other agencies clearly understood about the complexity of what the health visitors

were facing, and the time it took to work alongside parents to support parental understanding, were also identified as supportive.

Elwyn's three themes

Elwyn's Shared Decision Making Framework identifies three key stages within the process (Elwyn et al 2012). The first stage is where the professional identifies the opportunity to make a **choice**, the second stage takes place when **options** are identified and then once each partner in the process has put forward their views the third stage, a **decision**, is made in a collaborative way which takes both the professional's view and the patient's views and context into consideration – or else there is an agreement to defer a decision at this point.

Choice Talk

In cases where choices were offered, and particularly if the health visitor had identified the issue during a cognitive development assessment, although the choice of 'doing nothing' was never offered to a parent sometimes choice was given as to whether to delay requests for assistance to implement an intervention or not. This was to enable other strategies to be tried within the family first; however one health visitor recognised that she only offered this choice if, in her judgement, she believed the family would follow this through.

There was evidence of choice being given about which issue to address first if multiple issues were presented; however in general terms there were only limited amounts of data which identified that health visitors were explaining that there was a choice and what the choice was. It could be argued that this was appropriate because for choice to have been given between one intervention and another there would have needed to have been at least two options of interventions available – both or all with supporting evidence that they could improve the wellbeing of the baby or child; however within the study no example was ever given where two or more options of interventions were available to address an issue and choice was offered between them. Choices which were offered to parents related more to decisions about timescales of implementing interventions.

What was interesting was that health visitors believed they were giving choice, and parents believed that they were being offered choice, when there was little evidence that this was being offered in a meaningful way. This finding is consistent with Towle et al's (2006) findings and was reinforced by the responses to the questionnaires in Phase 1 where there was the

perception that a greater degree of choice, and shared decision making, was being offered to, and accepted by, the parent than was actually evident within each of the discussions. This raises the question as to why this should be, and the potential implications if parents believe they are being given a choice which is based on an unrealistic perception.

Health visitors are trained to empower parents and to give them the ability to make choices where they can, as they are aware that parents have a key role in the care of their children, and are more likely to engage with services if they have chosen to participate in the decision making process. In the interviews there was a tendency to use language which indicated 'choice', even in cases where a choice between interventions was not on offer. If parents believe they have been given a choice when this has not been the case this could lead parents to misunderstanding the need for implementing an intervention in the first place, unless the discussion about the impact of the issue on the child's wellbeing has been clear and is agreed.

Option Talk

To be able to articulate what the options were for the parents, interviews revealed that the health visitors believed it was important that they were clear in their own minds what participation in the intervention would mean for the parents. From the nine health visitor interviews in Phase 2 it was clear that if the option of an intervention was to be delivered by another agency the health visitors wanted to know about the appropriateness of the service, its evidence base, how to request assistance, and to know what would happen to the parents, in order to encourage their participation. The health visitors also wanted to know what processes would be used by the agency for contacting the parents after the request for assistance had been made so that they could explain this to the parents beforehand.

Some of the challenges sometimes is as health visitors not absolutely 100% knowing what the service is able to offer or how it's actually going to pan out
(Phase 2 HV 5)

Seven of the health visitors also wanted to know how the agency would make contact with the health visitor to provide feedback about the child's and parent's progress and what the agency would do if the parent failed to engage with the service.

INT:....the parenting programme,

HV: No you don't hear backand I had a child on the (Child Protection) Register and I didn't know whether they were attending or not.

(Phase 2 HV7)

Three parents identified that they also valued having information about other services beforehand

It's a shame that the health visitors don't have some kind of leaflet to give out, that would've been good

(Phase 2 Parent 2)

In two cases where communication with other services was effective the processes were described in a way which was streamlined, easy to explain to the parents, and less time consuming for the health visitor.

Data from two of the interviews included positive remarks in relation to creating 'Teams around the Child', based on 'Networks of Support' which consisted of a group of professionals, and the parents, meeting to support decision making around a child. They were found to be productive ways of informing parents directly what was on offer and to supporting them with their decision making during planning processes.

I think that processes have worked, you know, the liaison with everybody that's involved, you know, we have a team around the child, the parents can come to the meetings and so they've seen all the professionals who deal with the child in the community in the one place, and I think the message that that gives the parents as well is that nobody's taking decisions in a vacuum, that everybody talks to one another and they can come and talk to everybody at the one time

(Phase 2 HV3)

One health visitor spoke about the positive value she felt of having other members of the health visiting team, such as Staff Nurses and Nursery Nurses, available to implement interventions with parents. Another health visitor spoke about situations where there were no options, either from within their own team or within the community, suitable for the family, and the difficulties this created

it eventually just lands back with usthen we've got to contain them or do something with them which can be quite tricky

(Phase 2 HV 1)

Decision Talk

In the study there were examples of deep and meaningful conversations between health visitors and parents around what they could expect from other services, and evidence that

the health visitor had explored how the parents had felt about the decision to request assistance, participate in groups, or access a different service.

we talked about different situations, different children, you know, and really about gaining confidence that she'd maybe lost a bit of confidence about parenting

(Phase 2 HV 8)

However there were two examples which indicated that this level of discussion had only taken place *after* a parent had not taken their child to another service, as a way of establishing what the problem was and exploring what could be done to increase the likelihood of future engagement and participation.

Three health visitors indicated their sensitivity to the context which parents were living in and described their own range of feelings in relation to options available. For instance two health visitors spoke about delaying before addressing one of the issues as they recognised that the conversations could potentially be overwhelming for the parents at that time in their lives

so it was a very softly, softly saying 'I understand as much as I can where you are.....'

(Phase 2 HV 3)

What processes supported implementation of shared decision making?

In summary, the processes which were supportive, when using Elwyn's Model as a framework, revolved around the availability of evidence based options; the health visitor's ability to explain in detail to parents what implementation would entail for them; being able to 'take the parents with them' as part of the decision making process (as with the Team around the Child meetings); and having options of interventions available very quickly, such as when other Team members are able to follow up with joint visits and start implementation within days.

There was evidence that deep and meaningful conversations were taking place, that interactions were sensitive and responsive, and that this approach was well received and supportive of shared decision making. However there were also examples where health visitors reflected, within the interviews, and acknowledged that, in hindsight, they could

have enquired to a greater extent to establish the parents' views about participating in the interventions as part of the decision making process.

Dewar and Nolan (2013) talk about nurses being 'curious', 'courageous', and 'connecting with people' at an emotional level in order to provide patients with the individual support which they need in a personalised service.

Relationships

The Solihull Approach is a theoretical model which is used widely across health visiting practice in the United Kingdom (Solihull Approach 2013; Media Hub 2014). It was developed by health visitors and clinical psychologists and is based on established theories from psychology and child psychotherapy. The model takes into consideration three elements of relationships which overlap in practice; they are containment; reciprocity; and behaviour management. The ways in which these components manifested themselves within the health visitor and parent relationships was used as another layer of structure when analysing the data from both Phases 1 & 2.

Containment relates to a person's ability to receive and understand the emotional communication from another person without being overwhelmed by it (Bion 1959). In order to emotionally contain others (such as a baby or toddler) and not be overwhelmed a parent needs to be contained themselves. There was evidence that all health visitors were containing parents (to some extent) in relation to the parents' own personal issues, feelings, and emotions and there were descriptions from parents which reinforced the level of trusting relationships which had consequently built up between them and their health visitor.

Reciprocity was first described by Brazelton (Lewis and Rosenblum 1974) in the context of adult: infant relationships; however it can also be used to describe the interaction which takes place in all relationships. Reciprocity describes the initiation, regulation, and termination of an interaction where both parties are actively involved in the process. There was evidence of reciprocity in the two health visitor: parent dyads, where dialogue occurred back and forth and humour was used, and there was evidence of efforts to create equality in power by the health visitor through the language and tone of voice each used.

Behaviour management is based on learning theory and behaviourism (Skinner 1988) and refers to the attention and reward behaviours which one person can use to influence the behaviour of another. Behaviour management is less likely to be as effective if containment and reciprocity are lacking in a relationship; so it was of interest that, in the study, there was evidence of health visitors providing direction around behaviour management, and ideas being accepted and tried by parents.

In addition to evidence of strong trusting relationships between the health visitors and parents there were indications that other family relationships were important too, and could potentially influence decision making about the child, in addition to those decisions made between health visitors and parents; predominantly (but not exclusively) the mother. It became apparent that although health visitors were often aware of internal disputes in families between parents, grandparents and other family members, links between the impact of these relationships on decision making were sometimes missed – which in one case created a negative outcome.

their speech was delayed, their eye contact – there was concerns about their development. We at that point referred these children to Pre 5 Assessment Team and mum agreed with the referral, but when we went to the referral meeting, dad arrived and at that point mum told everybody at the meeting that she hadn't consented to the referral and that she'd felt quite pressured into it
(Phase 2 HV8)

Although there were examples of health visitors endeavouring to meet with fathers and grandparents this was not common practice and it was rare for them to be actively included in decision making.

The Solihull Approach is useful for health visitors to support analysis of their interactions with parents and children and it ensures that they are using well established theories from psychology and psychotherapy within their practice. There was evidence that where health visitors had been trained in using this model it gave them the language to describe what was happening and insight into why they needed clinical supervision to support them in their practice.

Discussion

In this study there was an indication that identifying the issue in a clear understandable, shared way was a pre-requisite for shared decision making to take place, but it did not

always appear to take place. It is not unusual for health visitors to agree on an issue with a parent, which requires addressing, as this structured approach is used when applying behaviour management strategies, motivational interviewing techniques and health behaviour change models to practice. The difference is that when implementing these approaches it is the norm to be applying frameworks or models to create structure to the conversations. This raises the possibility that development of a shared decision making framework, which includes the need to be clear about the issue, could support health visitor practice when planning in partnership with parents. A framework could also help the health visitors to determine whether there is a range of options available in the first place, and then whether they are physically and psychologically accessible to parents and the systems and processes surrounding them clear and accessible to health visitors.

Deep and meaningful conversations, supported by a sensitive and responsive approach, supported shared decision making to take place; and this approach requires health visitors to constantly reflect on their behaviours and continually increase their self-awareness.

In relation to building on their planning skills, and working collaboratively with parents, an understanding about decision making theories has the potential to support the process (Thompson et al 2013) . This would enable health visitors to differentiate between when choice is appropriate, and when other psychological and practical responses are more appropriate for the clinical context. Understanding would also enable health visitors to support parents with their role in decision-making.

As part of the assessment process of the child and their family, evidence from the study would indicate that children benefit if health visitors not only know about the Network of Support which is available *for* a child, but also know about the Network of Influence which exists *around* the child. This knowledge will increase the health visitors' understanding about family dynamics and is consistent with the scope of the GIRFEC National Practice Model. Increased understanding about the context within which a child lives will potentially improve the quality of shared decision making and also enable improvements in parental engagement with interventions designed to improve the wellbeing of the baby or child.

Conclusion

Despite evidence of strong trusting relationships between parents and health visitors, this study has shown examples where shared decision making was challenging when other supportive processes were absent. For shared decision making to have been effective every time there would have needed to have consistently been structure to the conversations; clarification, and agreement about the issue which was having an impact on the wellbeing of the child; accessible and acceptable interventions; deep meaningful conversations supported by curiosity in order to increase understanding about the dynamics within relationships in the families; and positive working relationships between health visitors and other professionals and agencies which provide interventions for families.

Relevance to clinical practice

Health visitors are aware that planning interventions in partnership with parents can be complex. These findings have identified the potential value of using a shared decision making framework to structure planning in collaboration with parents. The findings have also highlighted a number of areas where a review of systems and processes within organisations could support health visitor practice development.

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